No. 46161-7-II

**IN THE COURT OF APPEALS, DIVISION II,
OF THE STATE OF WASHINGTON**

STEPHEN NOEL, Individually and as Personal Representative of the Estate of NATHANIEL NOEL

Appellants,

v.

FRANCISCAN HEALTH SYSTEM, et al.;

Respondents.

APPELLANT'S OPENING BRIEF

THADDEUS P. MARTIN, ATTORNEY AT LAW

Thaddeus P. Martin, WSBA # 28175
Attorney for Appellants

4928 109th St SW
Lakewood, WA 98499
(253) 682-3420

TABLE OF CONTENTS

CASES

RCW

WPI

I. INTRODUCTION

This case involves a preventable death of a baby. This case was over time eviscerated by the Trial Court, which made one erroneous ruling after another, literally leaving nothing left to try once the case was called for trial.[1] According to the Trial Court, plaintiff Stephen Noel who lost one of his sons, Nathaniel Noel, does not have a claim for loss of parental consortium or the loss of a parent-child relationship under the terms of RCW 4.24.010. According to the Trial Court, Mr. Noel cannot bring a "failure to report" claim, because such claim can only be brought as a "survival claim", was unavailable to a parent, whose had a cause of action based on RCW 4.24.010.[2]

Finally, the Trial Court effectively ended this case when in response to a defense motion in limine, it excluded critical testimony from plaintiff's physician expert, regarding the cause of Nathaniel's death. As will be explored in detail below, every one of these rulings by the Trial Court were patently erroneous, and served to deny Stephen Noel, a father

[1] This case was initially brought against St. Clare Hospital and Dr. Ian D. Cowan, and DSHS. The claims against DSHS were settled prior to trial.

[2] The defense also argued that plaintiff cannot bring such a claim absent a showing of subjective actual knowledge on the part of the physician who allegedly failed to report child abuse as mandated by RCW 26.44.030.

who lost a son, an opportunity to justice, despite the culpability of these defendants in what was an exceptionally preventable death.

II. ASSIGNMENTS OF ERROR

1. The Trial Court erred by dismissing Stephen Noel's claims for the non-economic damages, which are available under RCW 4.24.010, which resulted as a byproduct of his son Nathaniel Noel's untimely death, which was due, in part, to the negligence and/or breach of statutory duties perpetrated by the defendants.

2. The Trial Court erred in dismissing Stephen Noel's "failure to report" claim, brought against a hospital and an emergency room physician, who failed to comply with the statutory duty to report child abuse, in violation of RCW 26.44.030, on the grounds that such a claim is a "survival claim" when Mr. Noel, as a parent, has a direct cause of action for such a claim, independent of Washington's wrongful death and/or survival laws, independently and which is actionable under the terms of RCW 4.24.010.

3. The Trial Court erred in determining that in order to have a "failure to report" claim against a hospital and emergency room physician who, failed to report child abuse, as required under the terms of RCW 26.44.030, because the physician lacked "subjective" knowledge that such an abuse was occurring.

4. The Trial Court erred in limiting by way of motion in limine, the proffered testimony of plaintiff's standard of care and proximate cause expert physician when, under the standards applicable to experts, such opinions were fully supportable and otherwise admissible.[3]

III. ISSUES RELATING TO ASSIGNMENTS OF ERROR

1. Did the Trial Court err by dismissing plaintiff Stephen Noel's general damages claims for the loss of the parent-child relationship and/or loss of parental consortium, which resulted from the untimely death of his son Nathaniel, when such damages are clearly authorized under the terms of RCW 4.24.010?

2. Did the Trial Court misconstrue the terms of RCW 4.24.010, to require a parent seeking general damages pursuant to RCW 4.24.010, for the wrongful death of a child, to prove injury above and beyond that which naturally flows from the death of a child?

3. Did the Trial Court erroneously dismiss plaintiff's claims pursuant to RCW 26.44.030, when a parent is within the class of individuals intended to be benefited by the statutory scheme which from

[3] As a result of the Trial Court's granting the defense motion in limine, to limit the opinions of plaintiff expert, plaintiff was unable to prove the essential element of proximate cause and the case was subject to dismissal and/or directed verdict in favor of the defense.

the basis for a statutory implied cause of action and has direct standing to bring such a claim?

4. Did the Trial Court abuse its discretion by granting the defendant's motion in limine limiting plaintiff's expert testimony, to such a degree, that plaintiff could not prove an essential element of his case (proximate cause), when such limitations resulted in a dismissal of plaintiff's case?

5. Was plaintiff's expert qualified to render opinions with respect to causation?

IV. STATEMENT OF FACTS

A. Factual Background of Case

Nathaniel Noel and his twin brother Stephen Noel were born on October 14, 2007 (CP 1181). There were four official referrals to Child Protective Services (CPS) starting just days after the birth. Once CPS is called for an intake, the agency officially becomes involved in the welfare of the child. (CP 1184, CP 1468:12-24, CP 1470:8-23). The referrals were taken by intake workers and supposedly reviewed by supervisors. The supervisors rarely questioned or reviewed the intakes. (CP 1460). The first referral was October 18, 2007; the second was December 3, 2007; the third was December 28, 2007 and the last referral was January 7, 2008. (CP 1196). The October 18, 2007 referral was received by the

Children's Administration, Child Protective Services due to the twins being born severely premature, medically fragile and hospitalized and the failure of the parents to visit. (CP 1196, CP 1538:6-9). When the parents did visit the hospital, the visits were extremely short, usually minutes. The short visits caused CPS concern. (CP 1351-1354, CP 1535:15-21). Hospital staff consistently reported concern to Children's Administration for Nathaniel's welfare before he was ever released from the hospital. (CP 1185). At one point, there were two or three weeks passed before the patents would visit Nathaniel in the hospital. Most times, the hospital was not able to reach them. (CP 1204). DSHS determined that the parents were unable to care for Stephen. But DSHS allowed the parents to keep Nathaniel despite the warning signs. (CP 1357).

The October 18, 2007 referral gave DSHS notice that the twins were born at 27 weeks gestation, about three months premature. The first time that Ms. Conway sought prenatal care was on October 4, 2007, just 10 days before the premature birth. (CP 1190). This was a concern to DSHS, along with other clear risk factors. (CP 1584: 2-21).

Before then, Ms. Conway did not know she was pregnant with twins. Id. DSHS was put on notice on November 7, 2007, that the hospital was having difficulty contacting the parents and that the parents were not visiting the newborns. This concern arose when Stephen

required an emergency life saving surgery on November 4, 2007. The parents could not be reached. (CP 1193). When the doctors attempted to explain their concern to Ms. Conway about her need to stay in contact with the hospital, which DSHS was aware of, the mother became defensive. (CP 1193). On November 7, 2007, CPS was made aware of this. (CP 1302-1307).

The December 3, 2007 referral to Children's Administration noted that the twins were still hospitalized and that despite encouragement to visit, the parents still did not visit Nathaniel because they seemed not to care about the children. CP 1185. DSHS specifically knew that the parents had not visited Nathaniel for a total of 26 days. They demonstrated a lack of bonding. CP 1198, CP 1165:23-1666:1, CP 1667:12-16. The parents signed a contract to visit the twins daily or to at least call in. They failed to do even that. CP 1198. DSHS and the Children's Administration were specifically warned that the parents were not attached or bonding with the twins. DSHS was specifically warned about the hospital staff's concern that the parents could not care for Nathaniel upon his discharge. Id, and CP 1181-1189. Specifically, the hospital noted that the parents were not participating in any care. CP 1198. On December 3, 2007, DSHS was put on notice of the "grave concern over the parents' lack of follow through and [the] fragile condition of the infants." CP 1198.

Dulce Ramon, a hospital employee, who reported her concerns about the parents' lack of bonding, made the CPS referral to DSHS worker Misty Sebastian. CP 1425-1427. At this point, DSHS had serious concerns about Ms. Conway's abilities to parent. She, in turn, had discipline problems. That, alone, was a safety issue. CP 1196, CP 1668:2-4, CP 1669:15-19. On December 6, 2007, CPS made a referral to the Early Intervention Program and a Public Health Nurse was assigned. Id. CPS knew that both Mary Bridge parenting Partnership Program and Pierce County Public Health were working with the parents in the home, but did not take seriously the information learned from these organizations regarding risks to Nathaniel. CP 1181-1189. The risks were known to DSHS on this date, including both parents working opposite shifts, unstable housing, and a lack of transportation that contributed to the parents not visiting the twins in the hospital. CP 1326-1328.

On December 11, 2007, Nathaniel was discharged from the hospital to his parents, while his brother Stephen remained hospitalized. CP 1186. Despite knowledge of the parents' inability to care for Nathaniel before he left the hospital, the baby was still entrusted to their care. CP 1528: 14-1529:2. On December 17, 2007, the Public Health Nurse said she witnessed Nathaniel strapped in a car seat in front of a window. His hands were "ice-cold." DSHS tagged this referral as

"negligent treatment or maltreatment." CP 1205, CP 1663:7-21. Just two weeks later, on December 28, 2007, after CPS spoke with the Public Health Nurse, a CPS Intake Worker generated another CPS referral based on observations by the nurse related to neglect and abuse of Nathaniel's mother, Dominique Conway. CP 1186. Specifically, CPS took note that Nathaniel's mother left him in a wet bib, with cold hands and sitting in front of a window. The temperature outside was cold. Id.

CPS was aware that the mother had difficulty parenting her two-year old child and struck him for no apparent reason. CP 1181-1189 and CP 1205. CPS characterized this at a Risk Level 4 out of 5, and then reduced the risk for no apparent reason. CP 1181-1189. A level 4 is just below emergent and "quite a concern." CP 1672:17-24. On December 28, 2007, DSHS formally charged that Nathaniel was neglected, "Mom is not meeting the needs of her preemie infant." CP 1208. Nothing was done to remove Nathaniel from the home. CP 1329. There were three allegations of neglect in the months prior to Nathaniel's death. CP 1345. CPS also noted months prior to Nathaniel's death that Ms. Conway "employs excessive/inappropriate discipline" and "lack of involvement in parenting." CP 1348.

Just a week later, on January 7, 2008, the Public Health Nurse

again warned CPS of Ms. Conway's inability to care for Nathaniel. Id. CPS was put on notice that Nathaniel was digressing medically under his mother's care, was not gaining weight, was missing critical doctor appointments and did not appear healthy. Id., at CP 1212, CP 1293, CP 1335. In fact, CPS knew that Nathaniel appeared as if he was failing to thrive. CP 1369. CPS was warned to keep Nathaniel warm because he was a preemie and Nathaniel was now two pounds less than his brother Stephen, who was now in foster care. CP 1212. CPS was also put on notice regarding the mother's excessive discipline, that she forced her six-year-old daughter to stand in time out for 30 minutes and that the two-year-old was out of control and a "danger to the infant." CP 1181-1189. Again CPS tagged the case as a risk level 4 out of 5, or a moderately high risk and assigned the case for investigation. CP 1181-1189, CP 1241-1244 (see also CP 1586-1587, CP 15-2:8-10).

In its investigation, CPS noted again that the family missed "several medical appointments" and that that Nathaniel was behind in immunizations. Id. CPS noted that Nathaniel did "not look healthy." CP 1212. CPS specifically noted that the family had a history of missing medical appointments and had difficulty feeding Nathaniel, verified by little weight gain. Id. CPS was concerned enough that it recommended that Nathaniel be placed in foster care. CPS never followed through. (This

included the concern of CPS supervisor Judy Mitchell. Id. CP 1539:13-25. The two-year-old in the home was described to CPS as a "Tasmanian Devil" and a "danger to Nathaniel" (the two year old "attempts to hit Nathaniel in the head and only screams.") It was noted that the mom, Ms. Conway, was always punishing the six-year-old. CP 1213. It was noted that the mother "yells, screams and spanks." CP 1213. CPS tagged Nathaniel's welfare as "moderately high (Neglect, Newborn preemie is not gaining weight, six-year-old is excessively disciplined; the two-year-old is out of control.)" CP 1216. CPS wrote "vulnerability to child: Nathaniel is at risk due to lack of weight gain and hyperactivity of his brother." CP 1216.

On January 11, 2008, CPS noted that there was a "concern that places [the] child in this home at risk of serious and immediate harm." CP 1257-1259, CP 1314-1323. At this time, CPS also knew that the family did not have a stable residence. CP 1261. The father, Mr. Noel, knew that the family could not handle the children and told CPS that he wanted to send them to the East Coast to live with his mother. CP 1264. CPS noted missed medical appointments on January 18, 2008. CP 1265. On January 16, 2007, DSHS was aware that the mother was having issues with housing, parenting and child development. CP 1318, CP 1593. CPS worker Ms. Murillo noted that the mother had a history of not following

through and not making medical appointments for the children. CP 1594:5-10; CP 1595:4-23.

CPS supervisor Julie Slaughter was aware of the intake allegations of neglect of Nathaniel, which was characterized by DSHS as moderately high risk to Nathaniel. CP 1639:14-24, CP 1642:3-16. Nathaniel died as a "moderately high risk tag" for abuse and neglect." CP 1643:13. On January 25, 2008, Nathaniel was medically diagnosed with weight loss. Id., at P. 6. CPS specifically noted the risk factors to Nathaniel, including "instability, a medically fragile infant, poor parenting skills, financial stressors and inconsistency with following through with tasks." Id., at P. 6. The only thing offered by CPS was "Intensive Family Preservation Services." The Intensive Family Preservation worker met with Nathaniel's mother twice a week and reported to CPS that she "presented as distracted during visits, often on the computer or engaged in other activities, preventing her from gaining the mother's full attention or engagement in services- another warning sign. Id. The worker was aware of other providers in the home "however had not been in contact with them." Id. CPS was also aware of a total of twenty-six (26) service provider visits to the home and specifically noted a "lack of progress in reducing identified risks factors within the family relating to parenting, housing stability, follow through with medical appointment, bonding with

Nathaniel and inconsistent contact" with the other hospitalized twin, Stephen. CP 1181-1189, Cp 1218-1219.

After Nathaniel's death, DSHS Child Fatality review committee, specifically noted "despite several providers involved with the family, communication between service providers as a means to address the family stressors and dynamics was limited and lacked collaboration." Id., at P. 6. DSHS described this as a "grave concern over the parents' lack of follow through and the fragile condition of the infants." CP 1241. CPS noted their concern over "neglect" related to Nathaniel. CP 1241.

By January 29, 2008, CPS was aware of four referrals, the fact that Nathaniel was still identified as a moderately high risk for neglect/abuse, medically fragile, was losing weight, and that the mother was still missing medical appointments. In addition the mother was having difficulty feeding Nathaniel. CP 1251. On January 29, 2008, CPS was also aware that the mother was not feeding Nathaniel enough formula "because [she said] it was too expensive." CP 1289.

The first time that DSHS met with the other providers to address Nathaniel's safety was on February 4, 2008 and the concerns were enough that CPS discussed the placement of Nathaniel's brother Stephen outside the home. Id. No action was taken regarding Nathaniel, who was in the

home. Id. CPS focused its attention on Stephen, who had never left the hospital. The warning signs concerning Nathaniel health and safety were ignored. Id. CPS admits that there was a concern for the health and safety of Nathaniel at this time "however its primary focus supported Stephen and his need for out of home placement." Id., and CP 1360-1368. But what about Nathaniel? On February 5, 2008, DSHS noted that the family was "homeless and living with a friend, five people in one bedroom." There was no privacy beyond that. CP 1412-1416. On February 6, 2008, Nathaniel's pediatrician informed CPS that the parents missed another medical appointment. Nathaniel was two months behind in his shots. Ex. 12, P. 74. CPS staffed the case and agreed to "extend an invitation to the mother should the mother feel she cannot care for Nathaniel and would like to place him in foster care." CP 1274. When CPS "extended this invitation" to place Nathaniel in foster care, Ms. Conway responded upset and rude, in total denial. CP 1276.

Amazingly, on February 15, 2008, less than a month prior to Nathaniel's beating death, CPS was put on notice of an alarming incident occurring on February 11, 2008, that clearly demonstrated that Nathaniel was in danger because the mother left the infant and the two-year-old home alone. CP 1276. According to the CPS chronological record:

> Social Worker went to family home to have mom sign VPA for Noel to go to foster care. Social worker knocked and knocked with no answer. Social worker could hear a small child continuously calling "mom, mommy, mama" over and over. Social worker went to car and called the phone, nut received no answer. Social worker was sitting in the car when social worker saw mom coming up the street. When social worker entered the home, social worker observed (two year old) standing on a chair at the computer. Mom went into the bedroom and came out with a crying Nathaniel (the infant).

CP 1276.

The mother stated that a man named David was in the backroom watching the infant Nathaniel but when the social worker asked Ms. Conway to produce "David", she refused.

Tonya Fox, supervisor with DSHS Family Preservation Services admits that the infant was home alone:

> Q. Does it appear from reading the chronological note that there was no adult in the same room as Nathaniel?
>
> A. Yes, from the note it appears.

CP 1566:23-25.

Ms. Anderson, the case worker, confirms that she witnessed the infant Nathaniel and the two-year-old home alone, with no other adults in

sight. CP 1615-1616. Ms. Conway, the mother, made an excuse that an adult named David was there watching the children and when Ms. Anderson requested that Ms. Conway produce David, Ms. Conway "refused" and was disagreeable. CP 1617:7, CP 1618:17-19. Ms. Anderson knew that this was not "normal" and that Nathaniel was at risk. CP 1617:3-Cp 1618:6, CP1618:23-25. This was coupled along with Ms. Anderson's concern that there was a lack of bonding with the infants, Ms. Conway's statement she was overwhelmed. There was a history of constantly missed medical appointments for Nathaniel, a high-risk premature infant. CP 1619-1620.

Ms. Anderson's supervisor, Ms. Fox agreed that there is no legitimate reason to ever leave an infant home alone. CP 1568:6-11. No new CPS referral was made by DSHS despite notice that the infant Nathaniel was left home alone. Law enforcement was not contacted. CP 1568:23-CP 1569:3. On February 15, 2008, CPS received Ms. Conway statement and warning that "she is not getting a break with the children and feels overwhelmed." CP 1277, CP 1568:9-12. DSHS, Family preservation Services supervisor Tonya Fox knew that Ms. Conway was overwhelmed and knew that she left the infant home alone. CP 1551:15-22, CP 1552:18-25, CP 1560:11-CP 1561:4. The CPS supervisor, Judy Mitchell, did not consider this fact, but agrees that CPS should have taken

action to protect Nathaniel from abuse and neglect. CP 1540:4-9. There is a clear indication that the DSHS agencies charged with the protection of children were compartmentalized and did not communicate with each other, i.e., each had their own part of the building. CP 1554:22-CP 1555:7. Ms. Fox agreed that she should have been acquainted with the totality of the record related to Ms. Conway and the risk associated with Nathaniel. CP 1569:7-13. CPS and Family Preservation Services, both DSHS, made chronological records that were part of the same ongoing record. CP 1571:9-17. Any DSHS worker could view the entire chronological report. CP 1624:10-13.

After Stephen was placed in foster care, CPS was specifically put on notice of two emergency room visits to St. Clare Hospital for Nathaniel in February and March of 2008. CP 1188. CPS was on notice that both visits involved facial and eye injuries to Nathanial. Id. DSHS's Family Preservation Services testified that they were not aware of these visits, even though they were part of the same chronological record. CP 1556:7, CP 1557:5-13.. The DSHS Family Preservations Services did not know that Nathaniel was "failing to thrive" even though CPS noted this in the chronological record. CP 1558:11-20, CP 1574:17-CP 1574:3. In fact, Nathaniel had not gained as much weight as his more fragile, hospitalized brother. CP 1646:8-16. DSHS documented that Nathaniel "did not look

healthy." CP 1648:10-15. DSHS was concerned that Ms. Conway would not be able to care for her children. Id at CP 1657:4-8. DSHS also knew and witnessed Ms. Conway use excessive discipline with the other children. CP 1647:8-18. DSHS knew that Nathaniel was not safe. In January, 2008, Nathaniel was found strapped into a car seat on the couch with the two-year-old jumping on the couch, screaming, yelling and spanking Nathaniel. CP 1648:16-25. Physical abuse and neglect should have been reported by DSHS to law enforcement. This was not done even though DSHS accepted the allegation of neglect and witnessed injury. CP 1655:19-25. Nothing was done to follow up on these allegations. CP 1658:12-21.

The Child Fatality Review noted: "On February 17, 2008, Nathaniel was seen for a broken eye vessel in his eye, and a diaper rash." Id., at P. 7. CPS specifically was aware of this first emergency room visit and discussed it with Nathaniel's mother on February 25, 2008 (two weeks before his death.) CP 1277. Specifically, on February 25, 2008, the mother informed Social Worker Christina Murillo that Nathaniel was seen at the emergency room for a "broken eye vessel in his eye." CP 1278, CP 1597:25-CP 1599:19. Ms. Murillo does not recall informing her supervisors of this injury and there is no record of any such conversation. Id, and at 29. When the social worker asked both parents whether

Nathaniel was crying a lot, both parents answered at the same time, Mom saying "no" and dad saying "yes, the baby is crying a lot." CP 1278. CPS also noted that Nathaniel had a "severe diaper rash." Id. Supervisor Fox admits that broken eye vessels in children are typically found in babies that are shaken or hit. CP 1572: 3-15. Ms. Murillo could have and should have contacted law enforcement to facilitate placement of Nathaniel outside of the home. CP 1563:15-24. Murillo also knew that Nathaniel was in a moderately high risk of abuse and neglect. CP 1601:25-CP 1602:2. Ms. Murillo agrees that so many children have died while the family has been under CPS investigation that there are too many to count. CP 1604:10-17. In all of those countless CPS death cases, none of the children were ever "determined to be in imminent danger" by CPS standards, according to Ms. Murillo. CP 1605:23-CP 1607:11.

On March 5, 2008, DSHS observed the mother with Stephen in a supervised visit after not seeing him for some time. She left without even kissing Stephen. CP 1369-1374. On March 5, 2008, CPS was made aware that the social worker had been calling the family, but got no response. CP 1282. On March 6, 2008, a DSHS social worker assigned to this case, Wanda Anderson, visited the home and saw an injury to Nathaniel's right eye (broken eye vessel later admitted to be the result of choking by the mother) and an abrasion under Nathaniel's chin, as

documented in the chronological record. CP 1284, CP 1608:9-18. At her deposition, Ms. Anderson testified that she did not see the eye injury. CP 1611:11-15. Ms. Anderson discussed the February 17, 2008 emergency room visit with the mother on March 6, 2008. CP 1188-1189, CP 1412. Ms. Anderson also admits that she did, in fact, physically hold Nathaniel on March 6, 2008. CP 1630:16-18. DSHS and Ms. Anderson were concerned enough that they took away one twin, allowing him go into foster care. CP 1621:2-13. A day later, March 7, 2008, Nathaniel was taken back to the ER with another eye injury. "[H]is eye appeared swollen and blackened." CP 1181-1189. Ms. Conway admitted punching Nathaniel twice in the head on March 5, 2008, blows strong enough to fracture his head and cause brain hemorrhaging.

At the March 6, 2008 visit, the social worker noticed two injuries to Nathaniel, an eye injury and a chin injury (CP 1373), yet, DSHS did not remove Nathaniel or seek medical care for him. Id, and CP 1412. The next time that DSHS heard anything about Nathaniel it was after his death. CP 1285. As stated in the Child Fatality Report:

> Upon learning of the ER visits, CPS did not follow up with either ER physician referencing the visits to confirm the parents' explanation or physician assessment." CP 1188.

Injury to an infant is a high risk to the welfare of the child and calls

for immediate removal, and law enforcement notification. CP 1500:15-19, CP 1501:3-16. Another alternative for the immediate removal is a dependency petition, which was done after Nathaniel's death for the immediate removal of the other children. CP 1586-1587. DSHS has emergency foster parents that are prepared to take in children on an emergency basis. CP 1501:17-22. DSHS also has the procedure and power to have children medically evaluated, when necessary. CP 1502:25-CP1504:14. CPS referrals from a hospital should be treated as high risk. CP 1520:3-11. DSHS, however, took no action. CP 1576:1-9.

On Friday March 7, 2008, at the insistence of the father, Nathaniel was again taken to the St. Clare emergency room for a new injury "due to the child's eye being swollen and blackened." CP 1375-1390. Two days later, Nathaniel was dead. The Pierce County Sheriff "observed bruise[s] on the infant's eyelid as opposed to around the eye which would have been indicative of a punch." Id., at P. 7. Autopsy results received on March 10, 2008 noted the cause of death as "non-Accidental trauma resulting in old and new brain bleeds and a skull fracture." CP 1188, CP 1223.. After the death, Ms. Conway admitted that prior to the March 7, 2008 emergency room visit, she punched Nathaniel twice in the head because he continually cried and would not stop." CPS admits that the agency was aware of three referrals charging neglect of Nathaniel. The

agency also notes that Nathaniel's twin brother, Stephen, was put in foster care due to those concerns. Yet, Nathaniel was not protected. CP 1223. Ms. Conway admits that Mr. Noel had nothing to do with her assault on Nathaniel. She said she was "overwhelmed with the children, she was upset over having to quit her job to take care of the children and Stephen Noel was working all the time." CP 1341. Ms. Conway admitted that Mr. Noel was not "involved in the day to day care giving of the children." Cp 1341.

Ms. Conway was charged with Murder, 2nd degree murder for punching Nathaniel in the head, causing his death. CP 1232. The Pierce County Medical Examiner found that Nathaniel endured a fatal skull fracture on the left side of Nathaniel's head, causing inter-cranial bleeding on the left side of his head. Cp 1342. Nathaniel's stomach was also found to be empty. CP 1342.

Below plaintiff submitted a detailed declaration from Kenneth H. Coleman, M.D. a family practice and emergency room physician who was retained to opine regarding the standard of care applicable to physicians and emergency departments as it relates to reporting suspected child abuse. Dr. Coleman in a declaration submitted before the Trial Court outlined in great detail the failures of defendant Cowan, M.D. the emergency room physician who saw Nathaniel Noel on March 7, 2008 at

St. Clare Hospital. Nathaniel perished three days later on March 10, 2008. Importantly Dr. Coleman, who relevant records relating to the death, provided:

> RCW 26.44.030 states that a practitioner, which includes physicians and nurses, shall report to the proper authorities if they have reasonable cause to believe that a child has suffered abuse or neglect. On March 7, 2008, Nathaniel Noel was observed and evaluated by Franciscan Health Systems (St. Clare Hospital) personnel (registered nurses Ross Lewis, R.N., and Fashti Johnson, R.N.) and the emergency room physician Ian Cowan, M.D. In this case any practitioner, both nurses and physicians, seeing an infant at 4 or 5 months of age with the described ecchymosis or bruise on the left orbit must have child abuse (non-accidental trauma) at the top of their differential diagnosis list. **This means that the standard of care requires that the consideration of non-accidental trauma must be excluded in an affirmative fashion before one can dismiss this as a diagnosis. There is nothing done or discovered in the emergency room department visit to remove child abuse as a likely diagnosis, which is a breach of the standard of care. Therefore a reasonably prudent practitioner, both the nurses and physician, had to have reasonable cause to believe that this child had suffered abuse or neglect. The reason for this is as follows. There was no known explanation for the bruise. The mother could not provide a known explanation for how it had occurred. Without an observed event to explain the bruise, a reasonably**

> **prudent practitioner had to assume possible child abuse, had to investigate further at that time, and report to the appropriate authorities. The nurses and physicians violated the standard of care by their failure to investigate further and by failure to report to appropriate authorities.**
>
> CP 1157, 1161

Stephen Noel the plaintiff in this action and the father of Nathaniel in a declaration filed with the Trial Court on November 16, 2012 pointedly provided in part:

> 5. Every night I came home and spent time with Nathaniel, holding, feeding and playing with him and changing diapers. I loved Nathaniel dearly and I had dreams for both twins when they grew up. I was not able to spend much time with them due to having to work so much to keep my family afloat. I visited Stephen in the hospital and when he was in foster care. ...
>
> 9. I am the person that initiated and insisted that Nathaniel be taken to the emergency room, on two occasions prior to his death. When Nathaniel passed away I was heartbroken and depressed. All of my dreams for the boys growing up together and having a great life together as brothers were destroyed. Not a day goes by that I don't think about Nathaniel and the man he could've become.

10. Stephen is now being raised by my mother in Atlanta, Georgia. I still keep in constant contact with Nathaniel's twin brother Stephen by phone and letter and I visit him when I am able. We remain close, especially after the loss of his brother. The loss of my son Nathaniel is one of the hardest things I have ever dealt with.

CP 1704-1706

B. Relevant Procedural History

This case was initially filed on February 4, 2011. Ultimately the operative pleading was plaintiff's amended complaint filed on May 9, 2012. The plaintiff brought claims for 1) medical malpractice; 2) action for injury or death of a child pursuant to RCW 4.24.010; 3) a claim for negligent investigation pursuant to RCW 26.44.050; 4) claims for negligent infliction of emotional distress and outrage; and 5) a claim for violation of RCW 26.44.030 (failure to report claim). CP 1-8.

Dr. Cowan, (joined by other defendants), moved for summary judgment asserting that the Estate's claims were limited to a claim for economic damages given the absence of statutory beneficiaries as required under the terms of RCW 4.20.020. CP 1016-1035. Additionally Dr. Cowan asserted that plaintiff Stephen Noel, Nathan Noel's father did not have a cause of action under the terms of RCW 4.24.010 because it could

not establish the "proximate cause" between the failure to report and Nathan's ultimate death. It was also claimed Stephen, could not prove his damages i.e. that there was a "parent-child relationship" which could be injured. *Id.* Finally, with respect to plaintiff's RCW 26.44.030 (failure to report claim), Dr. Cowan asserted that such a claim could only be brought under the terms of the survival statute and given the absence of statutory beneficiaries the plaintiff father lacked "standing", (for lack of better terms), to bring such a claim in his own right. *Id.* Dr. Cowan asserted that in order to establish such claim the plaintiff had the burden of proving that there was "a subjective suspicion of child abuse" by Dr. Cowan. CP 1031-1032.

On November 5, 2012, plaintiff filed a detailed opposition to defendants' motion for summary judgment. CP 1101-1136. Plaintiff submitted testimony of both a psychologist and a physician, Kimberly Barrett, Ed.D. and Kenneth Coleman, M.D. CP 1137-1173. (Substantial documentary support for plaintiff's claims was also filed). CP 1174-1681.

Despite plaintiff's vigorous opposition the Court granted in part and denied Dr. Cowan's motion for summary judgment. The Trial Court limited plaintiff's claims to economic damages (survival action under RCW 4.20.046) and dismissed Stephen Noel's personal claim pursuant to RCW 4.24.010 finding there is no history of fact for the respective

"proximate cause" and finding that such a claim could not be brought on behalf of the entity Estate. CP 1735-1736. The Trial Court also went so far as to dismiss plaintiff's claim pursuant to RCW 26.44.030 on the grounds that it was only a "survival claim" and "because there was no subjective suspicion of abuse". *Id.*

What remained of the case was a claim by the Estate for medical malpractice limited to the economic damage the estate suffered as a byproduct of Nathaniel's death.

The case was called for trial on March 24, 2014. By way of a motion in limine defendant's moved to substantially limit the testimony of standard of care and proximate cause expert Kenneth Coleman, M.D. Defendants' motion in limine to limit Dr. Coleman's testimony was filed on March 14, 2014. Defendants sought to limit Physician Coleman's testimony with regard to "causation", due to an alleged lack of expertise in that area of medicine as well as other aspects of his opinion. CP 2136-2176.

On March 24 and 25 the Trial Court heard oral argument with respect to the motion to limit Dr. Coleman's testimony. RP 3/24/14 P. 4-43. On March 25, 2014 the Trial Judge announced her rulings in open court. RP 2/25/14 P. 3-12. In her ruling the Trial Judge precluded plaintiff's expert, Dr. Coleman from testifying regarding cause of death

because his opinions in part was based on his consultation with non-testifying pathologist as well as the Criminal Court proceedings brought against Nathaniel's mother. Given the fact that the Trial Court has excluded plaintiff's essential causation expert testimony the defense prior to openings moved for a directed verdict based on the Trial Court's motions in limine. While disagreeing with the Trial Court's rulings regarding Dr. Coleman's testimony, plaintiff conceded that absent such proof he would not be able to meet the essential elements of his case. The Court granted the defendant's motion to dismiss and his appeal followed. *Id.* P. 18-22.

V. ARGUMENT

A. Standard Review Applicable to Motions for Summary Judge and Directed Verdicts

Appellate Court reviewed Trial Court decisions granting summary judgments *de novo*. *Sutton v. Tacoma School Dist. No. 10*, 180 Wn.App. 859, 864-65, 324 P.3d 763 (2014). A genuine issue of material exists where reasonable minds could differ on the facts controlling the outcome of litigation. Id. citing to *Ranger Ins. Co. v. Pierce County*, 164 Wn.2d 545, 552, 192 P.3d 886 (2008). If reasonable minds can reach only one conclusion on an issue of fact the issue may be determined on summary judgment. Id. Issues of law are also subject to *de novo* review. See *Klem*

v. Wash. Mut. Bank, 176 Wn.2d 771, 782, 295 P.3d 1179 (2013). Whether or not the defendant owed a duty to the plaintiff is also a question of law subject to *de novo* review. See *Martini v. Post*, 178 Wn.App. 153, 167, 313 P.3d 473 (2013).

With respect to the "*de novo*" review of summary judgment the Supreme Court long ago cataloged the standards applicable to such motions:

> (1) The object and function of the summary judgment procedures to avoid a useless trial; however, trial is not useless, but is absolutely necessary where there is a genuine issue as to any material fact.
>
> (2) Summary judgment shall be granted only if the pleadings, affidavits, depositions, or admissions on file show there is no genuine issue as to any material fact, and that the moving party is entitled to judgment as a matter of law.
>
> (3) A material fact is one upon which the outcome of the litigation depends.
>
> (4) In ruling on a motion for summary judgment the Court function is to determine whether a genuine issue of material fact exists, not to resolve any factual issue.
>
> (5) The Court, in ruling upon a motion for summary judgment, is permitted to pierce the formal allegations of facts in pleadings and grant relief by summary judgment, when it clearly appears, from uncontroverted facts set forth in the affidavits, depositions or admissions on file, that there are, as a matter of fact, no genuine issues.
>
> (6) One who moves for summary judgment has the burden of proving that there is no genuine issue of material

> fact, irrespective of whether he or his opponent at the trial, would have the burden of proof on the issue concerned.
>
> (7) In ruling on a motion for summary judgment, the Court must consider the material evidence and all reasonable inferences therefrom most favorably to the non-moving party, and when so considered, if reasonable men might reach different conclusions the motion should be denied.
>
> (8) When, at the hearing on a motion for summary judgment, there is contradictory evidence, or the movant's evidence is impeached, an issue of credibility is present, providing the contradicting or impeaching evidence not too incredible to be believed by reasonable minds. The Court should not at such hearing resolve a genuine issue of credibility and if such an issue is present the motion should be denied. (Citations omitted).

When reviewing a ruling on a motion for a directed verdict, the Appellate Court applies the same standards as the Trial Court. *Hizey v. Carpenter*, 119 Wn.2d 251, 272, 830 P.2d 642 (1992). A directed verdict is appropriate if, as a matter of law, there is no substantial evidence or reasonable inference to sustain a verdict for the non-moving party. *Harris v. Drake*, 152 Wn.2d 480, 493, 99 P.3d 872 (2004).[4]

---

[4] Although motion before the Trial Court, (which ultimately resulted in a dismissal) was characterized that as a "directed verdict", procedurally it was far more akin to a summary judgment following "opening statement". See *Hallum v. Mullins*, 116 Wn.App. 511, 515-16, 557 P.2d 864 (1976). As noted in *Hallum* at 515 "in this state, Trial Court's are unquestionably empowered to dispose of civil actions on the opening statement of counsel for the party", citing to *Impero v. Whatcom County*, 71 Wn.2d 438, 447, 430 P.2d 173 (1967). The notion for the right to enter judgment at the opening statement stage of a trial is based on the rationale that to do so prevents the unnecessary expenditure of time and money to both litigants and the Court. Id. That is essentially the rationale for the "directed verdict" here, and to the extent that it may make a difference it is plaintiff's position that the dismissal of this case should be reviewed by the Appellate Court under

General issues of negligent and proximate cause are not susceptible to summary adjudication. *LaPlante v. State*, 85 Wn.2d 154, 159, 531 P.2d 299 (1975). Both breach of duty and proximate cause can be proved, like any other fact by way of circumstantial evidence. *Ripley v. Lanzer*, 152 Wn.App. 296, 307 215 P.3d 1020 (2009).

Expert testimony alone on issues of "ultimate fact" may be in and of itself sufficient to overcome a motion for summary judgment. *Xiao Ping Chen v. City of Seattle*, 153 Wn.App. 890, 910, 223 P.3d 1230 (2009); *Eriks v. Denver*, 118 Wn.2d 451, 457, 842 P.2d 1207 (1992).

Finally, Trial Court rulings regarding the admission of evidence and/or the qualification of experts are reviewed under a "abuse of discretion" standard. *Johnston-Forbes v. Matsunaga* - Wn.2d - 333 P.3d 388 (2014).

For the reasons discussed below, based on the application of such standards, there is simply no question that the Trial Court engaged in a number of reversible errors in its management of this case. The notion that father does not have a claim under the terms of RCW 4.24.010,

---

summary judgment standards. Alternatively, as discussed in 30 WAPRAC § 1:1 (2013) Trial Court's rulings on motions in limine have been found to be tantamount to a grant of a motion for summary judgment, citing to *Ninvens v. 7-11 Hoagy's Corner*, 113 Wn.2d 192, 196-97, 943 P.2d 286 (1997) (summary judgment appropriate after Court excluded evidence the defendant had a duty to hire security guards and failed to do so); *RWR Management, Inc. v. Citizen Realty Co.*, 133 Wn.App. 265, 271, 135 P.3d 955 (2006) (motion in limine dismissed defendant individually from lawsuit); *Janson v. North Valley Hosp.*, 93 Wn.App. 892, 901, 971 P.2d 67 (1999) (Trial Court ruling on motion in limine with an effect summary judgment).

whether predicated on a theory of medical malpractice and/or a failure to report child abuse under the terms of RCW 26.44.030, for general damages, is simply preposterous. Further, it is and was legal error for the Trial Court to determine that a claim pursuant to RCW 26.44.030 can only be brought as a "survival" claim under our wrongful death laws. Such a claim can be a predicate theory for a claim for injury and/or death of a child under RCW 4.24.010. Further, given the fact that the cause of action implied on the terms of RCW 26.44.030 was intended not only to benefit children, but also their parents, Stephen Noel individually had such a claim well outside the scope of our wrongful death laws. In other words he has an individual claim under that statute independent of RCW 4.22. et. seq. or, for that matter RCW 4.24.010.

The idea that Mr. Noel, who submitted a declaration below discussing the impacts of the loss of his son, could not prove that the underlying "malpractice"/negligence, which resulted in the death of his son, did not "proximately cause" him injury is simple preposterous. CP 1704-1706. The same is true with respect to the Trial Court's determination that in order to bring a claim under that statute, for "failure to report", the plaintiff had the burden of proving defendant Dr. Cowan had subjective knowledge that abuse was occurring. Such a standard does not exist. There's no such standard under the law.

Finally, the Trial Court's, death blow, exclusion of the testimony of plaintiff's causation expert should not stand. Under the applicable standards set forth within ER 702 through ER 705 Dr. Coleman was and is fully qualified to render opinions with respect to causation and the kind of information he relied upon were sufficient in that regard.

B. The Trial Court Erred in Determining as a Matter of Law that the Plaintiff Parent, Stephen Noel, Does Not Have a Claim for Loss of Parental Consortium and/or Loss of the Parent-Child Relationship Pursuant to RCW 4.24.010 under the Facts and Circumstances of this Case.

RCW 4.24.010 provides in part under the heading of "action for injury or death of child" the following:

> A **mother or father**, or both, who has regularly contributed to the support of his or her minor child, and the **mother or father**, or both, of a child on whom either, or both, are dependent for support may maintain or join as a party an action as plaintiff for the injury or death of the child. This section creates only one cause of action, but if the parents of the child are not married, are separated, or not married to each other damages may be awarded to each plaintiff separately, as the trier of fact finds just and equitable ... in such an action, in addition to damages for medical, hospital, medication expenses and loss of services and support, damages may be recovered for the loss of love and companionship of the child and for injury to or destruction of the parent-child relationship in such amounts as under all of the circumstances of the case, may be just. (Emphasis added).

Bizarrely in this case the trial court held that Stephen Noel, as the father did not have any general damages claims under the facts and circumstances of this case. Such a determination was patently erroneous.[5] Under this statute a parent of an injured and/or wrongfully killed child is entitled to compensation for "the loss of love and companionship" of the child and "the destruction of the parent-child relationship" as distinct items of damages. See *Wooldridge v. Woolett* 96 Wn. 2d 659, 638 P. 2d 566 (1981). Also a parent is entitled to seek damages for not only these items but also for parental grief, mental anguish and suffering caused by the wrongful death of a child. See *Wilson v. Lund* 81 Wn. 2d 91, 491 P. 2d 1287 (1971).

Yet, despite the above-referenced declaration of Stephen Noel discussing his emotional pain and suffering following the death of his child and describing a bonded relationship despite Nathaniel's young age, the trial court nevertheless dismissed Stephen Noel's general damages claim under this statute.[6] CP 1704-1706.

---

[5] Plaintiff does not quarrel with the notion that **the estate** of Nathaniel Noel only has a claim for economic losses under the terms of RCW 4.20.046 given the absence of any statutory beneficiaries under the terms of RCW 4.20.020. See *Triplett v. D.S.H.S.* 166 Wn. App. 423, 268 P. 3d 1027 (2012).

[6] The Trial Court's order of December 18, 2012 is confusing on its rationale for dismissing Stephen Noel's claim pursuant to RCW 4.24.010. Dr. Cowan, in his underlying summary judgment pleadings argued that there was "no proximate cause" between any act on Dr. Cowan's part and the ultimate death of Nathaniel Noel. In passing Dr. Cowan also rather obscurely argued essentially that because there was lack of a bonded relationship between Stephen Noel and his son Nathaniel that Stephen could not

To the extent that the Trial Court intended to dismiss Stephen Noel's claim pursuant to RCW 4.24.010 on the grounds that Dr. Cowan's actions did not cause him direct personal injury, such a proposition naturally would be specious. The whole purpose of RCW 4.24.010 is to provide a parent a cause of action for an injury to the child and the damages naturally flowing therefrom and there is no requirement that a parent be directly injured under the terms of such a statute.

C. The Trial Court Erred in Dismissing Stephen Noel's Failure to Report Claim Pursuant to RCW 26.44.030.

Plaintiff, individually, has a cause of action under the terms of that statue or can pursue such a claim under the terms of RCW 4.24.010. The Trial Court's determination to dismiss Plaintiff's claim for violation of RCW 26.44.030, "on the grounds that this is a survival claim for which there are no statutory beneficiaries and because there was no subjective suspicion of abuse", was patently erroneous. RCW 26.44.020(18) defines a "practitioner" to include individuals licensed in medicine. Under the terms of RCW 26.44.030 medical practitioners, such as Dr. Cowan, are obligated to report suspected child abuse or neglect to appropriate

---

prove any of the above damages. Given the obscure nature of such an argument the trial court should not even have considered it because it failed to meet the obligations applicable to parties moving for summary judgment in Washington. See *White v. Kent Med. Ctr., Inc.*, PS 61 Wn. App. 163, 168, 810 P. 2d 4 (1991) (It is the responsibility of the moving party in a summary judgment proceeding to clearly state in its opening papers those issues upon which summary judgment is sought and the basis thereof).

authorities if they have "reasonable cause to believe" that such is occurring. See RCW 26.44.030(1)(b).

In *Beggs v. DSHS* 171 Wn. 2d 69, 77, 247 P. 3d 421 (2011), our Supreme Court recognized that there was an implied cause of action against a mandatory reporter who fails to report suspected abuse. RCW 26.44.020(1) defines "abuse or neglect" to mean, among other things, injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, ... In reaching such a conclusion the Supreme Court relied on its previous decision in the case of *Tyner v. DSHS* 141 Wn. 2d 68, 1 P. 3d 1148 (2000) wherein, based on a different part of the same section or scheme, the court found that the legislature intended to remedy for parent victims of negligent child abuse investigation and provided such parents with a cause of action.

In both *Tyner* and *Beggs* the court looked to the test for implied remedies set forth within *Bennett v. Hardy* 113 Wn. 2d 912, 784 P. 2d 1258 (1990), in order to determine whether or not an implied cause of action should be provided from a statute which did not provide for an express tort remedy. Under the *Bennett* test the following questions must be asked.

> First whether the plaintiff is within the class who especially benefit the statute was enacted; second, whether legislative intent, explicitly or implicitly supports creating or denying

> a remedy; and third, where they're implying a remedy and it's consistent with the underlying purpose of the legislation.

In *Tyner,* the court looked to RCW 26.44.010 in order to aid in the determination as to whom it was intended to be "especially" benefitted by the statute. RCW 26.44.010 provides in part "the State of Washington legislature finds and declares, the bond between a child and his or her parent, custodian or guardian is of paramount importance, and any intervention into the life of a child is also an intervention into the life of the parent, custodian or guardian …."

Based on such language, the court in *Tyner* found that a parent was amongst the class of individuals intended to be benefitted by the procedural safeguards set forth within RCW 26.44.050 and had an available cause of action for negligent investigation.

In *Beggs*, the court similarly looked to *Bennett*. As *Beggs* is based on the duty to report set forth in RCW 26.44.030, which is part of the same statutory scheme at issue in *Tyner*, it would make no sense, and would be absurd, not to look to RCW 26.44.010 for the determination as to whet her or not a parent was amongst the class of individuals intended to be benefitted by the implied statutory remedy recognized in *Beggs*. See *Ducote v. DSHS* 167 Wn. 2d 697, 222 P. 3d 785 (2009) (Only a parent and

not stepparents fall within the class of individuals protected with an implied cause of action for negligent investigation under RCW 26.44.050). As recognized in *Tyner* at Page 80 "... the legislatures emphasize the interest of a child and parent are closely linked. RCW 26.44.010. Thus, by recognizing the deep importance of the parent/child relationship, the legislature intended to remedy for both the parent and child if that interest is invaded."

Additionally, by permitting a claim pursuant to RCW 26.44.030 by a parent whose child is a victim of unreported abuse would be consistent with the underlying purpose of the statutory scheme and requirements of RCW 26.44.030. This is particularly so when what has issue is the death of a small child who will never have statutory beneficiaries under RCW 4.20.020. By providing a parent with a direct cause of action for a "failure to report abuse", particularly when such a failure to report is a proximate cause of a child's death would fulfill statutory purposes that otherwise could be undermined if those who failed to report remained civilly unaccountable due to the absence of any meaningful damage remedy. Presumptively by providing a parent with a meaningful tort action unconstrained by the vulgarities of our wrongful death and survival statutes will have "a salutary effect on the seriousness with which ..." mandatory reporters execute their responsibilities and fulfill their

obligations under this statutory scheme. See *Yonker v. DSHS* 185 Wn. App. 71, 81, 930 P. 2d 958 (1997). Stated another way "the existence of negligent liability will encourage, (mandatory reporters), to avoid negligent conduct and leave open the possibility that those injured by (mandatory reporters) negligence can recover. *Tyner v. DSHS* 141 Wn. 2d at 81, citing to, *Babcock v. State* 116 Wn. 2d 596, 622, 809 P. 2d 143 (1991). "Accountability through tort liability ... may be the only way of assuring a certain standard performance by government entities." *Bender v. City of Seattle* 99 Wn. 2d 582, 590, 664 P. 2d 492 (1983). While what is not at issue in this case is "a governmental entity" Dr. Cowan **was, and is, a mandatory reporter under the terms of this statutory scheme**.

Thus, the position taken by the defense below, and adopted by the trial court that Stephen Noel does not have a claim under the terms of this statute was and is simply without merit.

Further, given that such a claim is directly vested with parents, there is simply no requirement that when a child's death is involved that such a claim be brought pursuant to any particularized statutory scheme. The cause of action belongs to the parent. However, to the extent that such a cause of action must be brought pursuant to one of Washington's wrongful death statutes the appropriate statute would be RCW 4.24.010 with respect to the **parent's claim** under this statute (versus that of the

deceased child's claim). There is nothing within the terms of RCW 4.24.010 which in any way restricts a parent's claim for an injury or death of a child to any particular type of cause of action.[7]

There is nothing within RCW 4.24.010 which in any way suggests that its coverage is limited to any particular cause of action relating to the underlying injury and/or death of a child. In other words a parent is entitled to a cause of action under the terms of this statute whether or not the child is a victim of an intentional tort or a wide variety of negligent torts including statutory causes of action. Thus the trial court's determination that such a claim can only be brought at a "survival action" was wrong.

Finally, the terms "reasonable cause to believe" is not a subjective knowledge standard. the Court should reject out of hand Dr. Cowan's suggestion that plaintiff is somehow obligated to prove that he had a "subjective suspicion" of child abuse as a predicate for his liability under RCW 26.44.030. As discussed in *Yonker v. State*, 85 Wn. App. 71, 80, 930 P.2d 958 (1997) given the importance and strong public policy in favor of eradicating child abuse, under the terms of RCW 26.44. et seq.

[7] RCW 4.24.010 only requires that the parent be dependent upon a child for support when the child who has passed away is **an adult child**. See *Vernon v. Aacres Allvest, LLC* – Wn. App. – 333 P. 3d 534 (2014). With respect to "**minor children**" the key question is whether or not the parent is contributing to the support of the minor child. See *Estate of Bunch v. McGraw* 174 Wn. 2d 425, 436, 275 P. 3d 1119 (2012).

should be triggered when there is "a possible occurrence of abuse". As pointed out in *Yonker*s at Page 80 "Nothing in that section implies that the State's duty to investigate arises only when it has a report of actual abuse. To the contrary, the relevant statute specifically requires investigation 'of a report concerning *the possible occurrence of abuse*'". (*Original*). As emphasized in *Yonkers*, "The purpose of RCW 26.44 is an effort to 'prevent further abuse and to safeguard the general welfare of children". The reason why a tort remedy has been implied onto this statutory scheme, is a recognition that potential tort liability for those falling within the statutory coverage and who are obligated to eradicate abuse, should answer in tort if they fail to reasonably perform their duties, "Presumably the legislature takes the view that tort liability will have a salutary effect on the seriousness of which the State executes its responsibility. As the Supreme Court observed in a related context, 'The existence of some tort liability will encourage DSHS to avoid negligent conduct and leave open the possibility that those injured by DSHS's negligence can recovery". Citing to *Babcock v. State*, 116 Wn.2d 596, 622, 809 P.2d 1143 (1991). To permit a "subjective" standard as opposed to an objective "reasonableness standard" upon statutory reporters would absolutely defy statutory purposes. In addition, such an interpretation is simply unsupported by the language of RCW 26.44.030 which requires reporting

when a mandatory reporter "... has reasonable cause to believe that a child has suffered abuse or neglect ..."

Given the language utilized i.e. use of the words "reasonable cause", the statute should be interpreted to apply negligent standards. The court can take note that negligence by definition is "... the failure to exercise ordinary care. It is the doing of some act that a **reasonably careful person would not do under the same or similar circumstances or the failure to do some act that a reasonably careful person would have done under the same or similar circumstances.**" See WPI 10.01. The standard of care applicable in negligence cases is an "objective" standard and not a subjective one. See *Ramey v. Knorr*, 131 Wn. App. 672, 124 P.3d 1314 (2005). Without further guidance from the legislature, when it is suggested that the Court should find that use of the term "reasonable cause" is simply application of the standard of "reasonable care".[8]

[8] In none of the cases where RCW 26.44.030 or 050 have been discussed is there any indication that a heightened standard of care is applicable to such claims. It is noted that in the case of *Mason v. Bitton,* 85 Wn.2d 321, 534 P.2d 1360 (1975), where the Supreme Court implied a remedy onto RCW 46.61.035 (statute applicable to authorized emergency vehicles) the Supreme Court opted for a reasonable care standard when interpreting the statute even though RCW 46.61.035(4) includes the terms that the exception to the rules of the road it affords included the language "nor shall such provisions protect the driver from the consequences of his or her **reckless disregard** for the safety of others"). The Court also can take note that in *Vennett v. Hardy*, 113 Wn.2d 912, 784 P.2d 1258 (1990) the Supreme Court which implied a statutory remedy in favor of employees of small firms for age discrimination under the terms of RCW 49.44.090 created the implied cause of action identical to a statutory discrimination claim. There is

D. The Trial Court Erred in Eviscerating Plaintiff's Case by Excluding Plaintiff's Highly Qualified Expert's Testimony With Respect To Causation.

As recently reiterated by our Supreme Court in the case of *Johnston-Forbes v. Matsunaga* – Wn. 2d – 333 P. 3d 388 (2014) generally expert testimony is admissible if (1) the expert is qualified, (2) the expert relies on generally accepted theories in the scientific community, and (3) the testimony would be helpful to the trier of fact. As reiterated in *Johnston-Forbes*, in Washington there are four main evidence rules regarding the use of expert witnesses. ER 702 generally establishes that when expert testimony may be utilized at trial: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise.".

ER 703 allows experts to base his or her opinions on evidence not admissible in evidence and to base his or her opinions on facts or data perceived or made known to the expert at or before the hearing. ER 704 allows an expert to testify on the ultimate issue the trier of fact must

---

simply nothing within the language or case law, which would in way suggest that the Court should utilize anything other than regular negligence principles applicable to the subject statutory scheme. It is again noted that to do so to eviscerate statutory purposes.

resolve. And finally ER 705 indicates that an expert need not disclose the facts on which his or her opinion is based although the court may require their disclosure and the expert may be subject to cross-examination on them.

Again as emphasized in *Johnston-Forbes* an expert may be qualified based on experience alone. Citing to *In re Marriage of Katare* 175 Wn. 2d 23, 39, 284 P. 3d 546 (2012). Expert testimony need not be based on personal knowledge or the personal perceptions of the expert under the terms of ER 703. *Id.* Experts, are permitted to, among other things, base their opinions based on the testimony of others. See *Carter v. Massey – Ferguson, Inc.*, 76 F. 2d 344 (5th Cir., 1983) (Plaintiff's expert was properly allowed to express an opinion on the cause of an accident on the basis of the plaintiff's testimony). Under the terms of ER 703 an expert opinion need not be based on facts otherwise admissible in evidence if the information is of the type reasonably relied upon by an expert in the particular field. This proposition applies to otherwise inadmissible hearsay. See *In re Detention of Leck* – Wn. App. – 334 P. 3d 1109 (2014). Indeed under the terms of ER 705 a trial court can allow an expert to relate hearsay or otherwise inadmissible evidence to the trier of fact to explain the reasons for his expert opinion, subject to appropriate

limiting instruction. *Detention of Marshall v. State* 156 Wn. 2d 150, 162, 125 P. 3d 111 (2005).

With regard to expert medical testimony which ultimately was at issue below, all that is necessary for such testimony to be admissible that it meet the standard of "reasonable medical certainty or reasonable medical probability". *Anderson v. Akzo Noble Codings*, 172 Wn. 2d 593, 607, 260 P. 3d 857 (2011); see also *O'Donoghue v. Riggs* 73 Wn. 2d 814, 822-23, 440 P. 2d 823 (1968). As recognized in *Anderson,* many expert medical opinions are pure opinions and are based on experience and training rather than scientific data. *Id.* at 610. Indeed, medical opinions often take into consideration a variety of factors particularly when it relates to causation such as temporal factors and the utilization of differential diagnoses which rule out other potential causes. *Id.* See *Reese v. Stroh* 128 Wn. 2d 300, 907 P. 2d 282 (1995).

Finally, while the determination as to whether or not to admit evidence generally lies within the sound discretion of the trial court when a trial court abuses its discretion by applying the wrong legal standard to the evidence. See *Reese v. Stroh* 128 Wn. 2d at 310. So long as the expert is willing to state a causation opinion based on a reasonable degree of medical certainty based on their experience nothing more is required. *Id.*

Here, the Trial Court largely limited causation testimony on the grounds of "hearsay" which is not a legally valid basis for the exclusions of expert testimony- experts almost always rely on "hearsay" of one form or another. Further, simply because an expert consulted with others in confirming these opinions, is supportive of the validity of the opinions and not the grounds for it's' exclusion.

The Trial Court abused its discretion by failing to follow the laws applicable to experts and should not limit Dr. Coleman's testimony.

VI. CONCLUSION

For the reasons stated above, Appellant requests that this Court reverse and remand.

Executed this 13th day of November, 2014, at Lakewood, Washington.

By _____
Thaddeus Martin, WSBA No. 28175
Attorney for Appellant

CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT I AM NOT A PARTY TO THIS ACTION AND THAT I PLACED FOR SERVICE OF THE FOREGOING DOCUMENT ON THE FOLLOWING PARTIES IN THE FOLLOWING MANNER(S):

Michelle Garzon
Williams Kastner
1301 "A" Street, Suite 900
Tacoma, WA 98402

Christopher H. Anderson
Fain Anderson VanDerhoef PLLC
701 5th Ave. Ste 4650
Seattle WA, 98104

[XXX] by causing a full, true, and correct copy thereof to be E-MAILED to the party at their last known email address, per prior agreement of the parties, on the date set forth below followed by legal messenger.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Executed at Tacoma, Washington on the 13th day of November, 2014.

Kara Denny

Kara Denny, Legal Assistant